

*****TESTIMONY IS EMBARGOED UNTIL 9:30 AM ON
FRIDAY, SEPTEMBER 21, 2012*****

Testimony

for

**House Ways & Means Committee
Subcommittee on Health**

Medicare Advantage Special Needs Plans

by

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September 21, 2012

I. Introduction

Chairman Herger, Ranking Member Stark, and members of the subcommittee, I am Dr. Tim Schwab, Chief Medical Officer at SCAN Health Plan (SCAN). SCAN is the third largest not-for-profit Medicare Advantage Prescription Drug (MAPD) plan in the United States, serving approximately 130,000 members in California and Arizona. While most of SCAN's members are over the age of 65, we also provide care to some younger, disabled individuals who are dually-eligible for Medicare and Medicaid benefits ("dual eligibles").

We appreciate this opportunity to testify on the innovative programs that SCAN has put in place to meet the needs of our most vulnerable and frail members. In particular, my testimony will focus on SCAN's Special Needs Plans (SNPs). These Medicare Advantage (MA) plans serve members who reside in institutional settings, or who reside in the community but require an equivalent level of care; manage multiple chronic conditions; and/or are dual eligibles. Since the program's inception, SNPs have pioneered successful strategies to manage the care of Medicare beneficiaries with complex health needs. Our testimony includes the following:

- An introduction to SCAN and the people that we serve;
- A brief background on SNPs, and the added value that they provide to the Medicare program;
- The successful health outcomes and cost savings that SCAN's SNPs have produced; and
- Recommendations for strengthening SNPs for Medicare beneficiaries going forward.

II. SCAN Health Plan

SCAN has a long history of serving older adults with complex health situations. SCAN was founded in 1977 by a group of Long Beach, California senior citizen activists who were frustrated by a lack of access to health and social services that addressed their specific needs. They specifically wanted assurance that they could continue living in their own homes even if their declining health qualified them for a nursing home. SCAN's mission today is the same as it was then: to develop innovative ways to help our members manage their health and live independently. For more than two decades, SCAN participated in Medicare's Social HMO Demonstration, incorporating long-term services and supports (LTSS) with a comprehensive program of assessment and care management. It was through our experience as a Social HMO that SCAN developed an expertise in crafting benefits and services of unique importance to persons with special care requirements.

Because of the complex nature of our members' health conditions, SCAN has created a care management model that emphasizes prevention and early intervention, with a keen focus on medication management. Our model spans the continuum of a beneficiary's health status. Our disease management programs focus on recognizing disease-specific symptoms and actions to take, when to call the doctor or seek urgent/emergent care, nutrition, self-management and healthy behaviors, advance care planning and medication management. Highly-trained care teams address the complex needs of the chronically ill population, and each program is

coordinated with all others to ensure safe and effective care transitions between all levels of care and providers. All those involved work together in offering a person-centered, holistic approach for persons with multiple, complex, and ongoing care needs. The *New England Journal of Medicine* has cited SCAN's model as an example of a successful investment in primary care to provide better care at reduced costs through reductions in the use of hospitals and emergency rooms.¹

III. Background and Value-Add of SNPs to the Medicare Program

The bipartisan Medicare Modernization Act of 2003 (MMA) established a new type of MA plan that focused on providing coordinated care to individuals with particularly complex health conditions. Congress intended these "Special Needs Plans" (SNPs) to exclusively serve one of three types of special needs individuals: (1) institutionalized beneficiaries, or individuals living in the community who require an equivalent level of care (I-SNP); (2) dual eligibles (D-SNP); and/or (3) beneficiaries with severe chronic conditions (C-SNP).² Because SNPs target their enrollments to particular patient populations, they can design programs that meet a group's unique health care needs and successfully reduce hospitalizations and institutionalizations.

All SNPs must offer Medicare Parts A, B, and D benefits, and must function under most of the same rules governing MA plans, including payment methodology. Additionally, SNPs are statutorily and administratively required to tailor benefits and services to their unique targeted populations. One difference is that Medicare enrollees may not have to wait until a new plan year to join SNPs. A person who reaches institutional or dual eligible status may enroll in a SNP at any point throughout the year. Beneficiaries with chronic conditions have a one-time special election period, based upon the time at which they are diagnosed with the chronic condition.³

Since 2003, Congress has enacted additional requirements for SNPs aimed at improving SNP performance and quality. These include:

- National Committee on Quality Assurance (NCQA) approval by 2012
- Individual care plans developed with input from beneficiaries and, if desired, families
- Annual comprehensive assessment of enrollee's physical, functional, and psychosocial health
- Interdisciplinary care teams with composition based on special needs of targeted enrollees
- Third party validation of institutional level of care equivalence

¹ Bodenheimer T., Berry-Millet R. (2009) Follow the Money – Controlling Expenditures by Improving Care for Patients Needing Costly Services. *New England Journal of Medicine*, 361:1521-1523.

² Special Needs Plans – Fact Sheet & Data Summary. Centers for Medicare and Medicaid Services. Available at <http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/downloads/FSNPFACT.pdf>.

³ The Basics About Special Needs Plans. National Health Policy Group. Available at <http://www.nhpg.org/about-snps.aspx>.

- Mandatory contracts with state Medicaid agencies for contract year 2013 and beyond which require D-SNPs, at a minimum, to:
 - Coordinate Medicare and Medicaid benefits and services;
 - Provide or arrange for the provision of Medicaid services;
 - Ensure that beneficiaries are not being charged higher cost sharing than Medicaid fee-for-service;
 - Include prohibitions in provider contracts against balance billing; and
 - Include in their summary of benefits a list of all Medicaid benefits to which the beneficiary is entitled in his or her state of residence, and which of these services are covered by the plan.

In addition, CMS rules require all SNPs to provide additional benefits and services of unique importance to their targeted populations – in addition to all those provided by standard MA plans – without additional payment. They must also attest to hundreds of SNP-specific requirements for staffing, health risk assessment, individual care plans, interdisciplinary care teams, provider networks, quality, etc. as a requirement for licensure. Further, to receive NCQA approval, SNPs must provide an extensive narrative description of their Model of Care (MOC), and supportive documentation, for the 11 MOC domains.

As of September 2012, over 500 SNPs are serving 1,530,935 beneficiaries across the United States. Of the total SNP enrollment, 1,259,446 beneficiaries are enrolled in a D-SNP.⁴ SCAN runs the nation's largest non-institutional I-SNP and one of the few CMS-certified fully-integrated D-SNPs (FIDESNPs) that provides extensive integration of Medicare and Medicaid benefits and services under a single program. In addition, SCAN provides specialty care for persons with end-stage renal disease through a C-SNP.

The advantages of SNPs to beneficiaries and public payors alike are clearly evident in the results of the SNP Alliance's 2010 Annual Member Profile. The SNP Alliance represents 30 organizations serving over 650,000 beneficiaries in more than 250 SNPs. The most recent profile shows that SNP Alliance members serve significantly more complex, high-need beneficiaries than those in Medicare fee-for-service (FFS). For example, while the average risk score for FFS beneficiaries living in institutions was 1.84, SNP Alliance members' median risk score for I-SNPs was 2.14, with an upper range of 2.27. The average risk score for SNP Alliance fully-integrated FIDESNPs was 1.49 compared to 1.27 for dual eligibles in FFS. SNP Alliance enrollees also had, on average, twice as many HCC conditions as beneficiaries in FFS. Despite these significantly higher risk levels, SNP Alliance members have been highly effective in reducing hospital utilization, readmissions, and emergency room visits.

⁴ Special Needs Plan Comprehensive Report. CMS Health Plan Management System. September 2012. Available at http://www.nhpg.org/media/15488/snp_2012_09.pdf.

IV. SCAN's SNP Experience Shows Improved Health Outcomes and Potential for Significant Cost Savings

Because SCAN's members are, overall, older and frailer than the average Medicare beneficiary, the availability of targeted, coordinated care options is particularly important. SCAN offers I-SNPs, D-SNPs, and C-SNPs to our members, with a total SNP enrollment of approximately 16,000 individuals. The full host of case management services is available to enrollees in a SCAN SNP, including the creation of a personal care plan, care transitions assistance, disease management, and medication therapy management. Approximately 8,000 of our members are dual eligibles enrolled in one of SCAN's D-SNPs. In addition to the case management services available to other SNP members, D-SNP enrollees have access to a Personal Assistance Line (PAL) Unit. SCAN provides these members with a "PAL," a member services representative who speaks their language and provides additional assistance in navigating the complexities of the Medicare and Medicaid programs. PALs act as liaisons between the member and SCAN staff, medical groups, providers, and community-based organizations, ensuring that the member has access to the services and supports that he or she needs.

Recent analyses of this unique care management model demonstrate its effectiveness in improving patient health outcomes. A March 2012 study conducted by Avalere Health found:

- Comparing HEDIS 30-day All-Cause Readmissions Rates between dual eligibles enrolled in a SCAN Health Plan D-SNP versus Medicare fee-for-service (FFS) dual eligibles, SCAN's dual eligibles had a **hospital readmission rate** that was **25 percent lower** than a similar cohort of California FFS dual eligibles.
- SCAN also scored better than Medicare FFS on ARHQ's Prevention Quality Indicator (PQI) Overall Composite, demonstrating a **14 percent lower hospital inpatient admission rate** for conditions that compose the composite measure, including chronic obstructive pulmonary disease (COPD), congestive heart failure, and bacterial pneumonia.

The study also found a potential for significant cost savings tied to the improvement in health status of SCAN's D-SNP enrollees. Based on the results of a matched cohort analysis, if California FFS duals had the same hospitalizations and readmissions rates as SCAN's duals, this would result in at least \$50 million in annual savings to Medicare FFS in California.⁵ Avalere based the calculation on expected reduced hospitalizations and re-hospitalizations for the 5,500 FFS dual members it examined in the CMS 5% sample, multiplied by 20 to approximate the impact to the full California FFS duals population. Avalere has said that savings could be greater across the entire California duals population if additional FFS duals matched the SCAN members' conditions.

⁵ Dual Eligible Population Analysis for SCAN Health Plan: Hospitalizations and Readmissions. Avalere Health LLC. March 2012.

V. Recommendations for Strengthening SNPs to Ensure the Continuous Availability of High-Quality Care for Medicare Beneficiaries

The SNP model of providing patient-centered, coordinated care to vulnerable populations has been a success. Unfortunately, current SNP authorization is set to expire at the end of 2013. Congress should act as soon as possible to extend SNPs for a period of at least five years. Moving quickly is imperative, given that health plans must file their notices of intent to offer these plans for the 2014 year by November 2012 and meet a series of other requirements by next August that assume contract renewal for 2014.

A multi-year extension would:

- Stabilize specialty care for the 1.5 million current special needs beneficiaries and provide them peace of mind regarding their existing care plans
- Continue the progress SNPs are making in reducing ER visits, hospitalizations, re-hospitalizations and nursing home stays
- Allow states, if they choose, to construct their duals demonstration on a SNP framework
- Allow SNPs to be a Medicare-based alternative to the duals demonstration in other states to see which model works best for beneficiaries
- Allow time to gather experience and evaluate findings from SNPs, ACOs, PACE and the Duals Demonstration so that CMS may work with Congress to enact a permanent program going forward

In addition, Congress should consider:

1. Allowing long-term services and supports (LTSS) to be offered through all SNPs. Under current law, only D-SNPs are authorized to provide these supplemental benefits. Avalere's study of SCAN's D-SNP shows the importance of LTSS to the health of individuals with complex health conditions, as well as to controlling costs within the Medicare program. Extending the availability of these services to all SNPs would amplify these results and improve the care available to Medicare beneficiaries.
2. Reducing financial barriers to specialization by directing the Secretary of Health & Human Services to improve the accuracy of the MA risk adjustment methodology to more fully account for cost differences associated with plans specializing in care of high-risk/high-need beneficiaries. This could be accomplished by: (1) adding new risk factors for frailty, dementia, and number of chronic conditions; (2) extending the new enrollee factor for C-SNPs to include D-SNPs; and (3) permitting all SNPs to offer expanded supplemental benefits, not just FIDESNPs.
3. Ensuring that SNPs are evaluated based on their performance in relation to their specialty care mandate. Congress should require CMS to establish population-based performance evaluation measures and methods, in collaboration with the National Quality Forum (NQF) and NCQA. This would ensure that SNPs are assessed based on measures that are sensitive to the unique but diverse needs of SNP beneficiaries, rather than standard

measures for general Medicare enrollees. A good starting point would be to require NQF to develop recommendations regarding measures for plans serving high-risk/high-need beneficiaries, after reviewing the appropriateness of existing measures and Star ratings. In addition, NQF should assess the need for new measures; the validity and reliability of self-report surveys for beneficiaries with mental illness, cognitive impairment, and behavioral problems; and opportunities for streamlining and consolidating current measures for SNPs – including Medicare and Medicaid reporting requirements – without jeopardizing SNP quality and risk-adjusting and benchmarking SNP performance against FFS.

VI. Conclusion

Persons who are poor, frail, disabled, and chronically ill are among healthcare's most vulnerable, high-cost, and fast growing care segments. Their multiple, complex, and ongoing care needs are poorly served by fragmented care models. Unless we promulgate specialty care arrangements for these high-cost/high-need beneficiaries, we will not be able to stem the tide of cost escalation, nor maintain our commitment to service for our most needy citizens.

As it stands, SNPs are the only managed care entity, other than PACE, able to exclusively serve persons who are dually eligible for Medicare and Medicaid – critical to the advancement of dual integration programs. SNPs are also the only managed care platform required to offer a model of care of unique importance to frail, disabled, and seriously ill persons, with CMS using a commensurate set of oversight and reporting requirements, also not required of other managed care entities. If states and local communities are empowered to build upon programs like SCAN's, with proper refinement of program, payment, and oversight requirements, a timely new generation of specialized care can emerge for bending the cost curve while actually improving care for our most needy citizens.